Demographic Transition and Gender Inequalities in Maharashtra

TARA KANITKAR AND ANJALI RADKAR

With demographic transition, social development has to take place reducing gender inequalities. Demographic transition is almost complete in Maharashtra as it is one of the developed states in India. Unlike transition, gender inequalities cannot be quantified accurately. They have to be studied through the data available on the behavioural patterns of the people. Looking at attitudes of the people as expressed through behaviour, an attempt has been made in this article to search for the gender inequalities. Unfortunately, the gap still persists. On the contrary, certain crude indicators like sex ratio even indicate that it has widened. Due to the small family norm and acceptance of terminal methods of contraception immediately after the desired family size is reached, son preference is becoming more visible. Family planning is absolutely women-centred and participation of men is negligible. In spite of an increase in the educational levels of women, as also their participation in the labour force, women get little support from the men, even when they are pregnant. Unless there is gender equity, demographic transition carries no meaning in the true sense.

Dr. Tara Kanitkar is Retired Professor, International Institute of Population Sciences, Mumbai, and is currently a Consultant at the Institute of Health Management, Pachod, Maharashtra. Dr. Anjali Radkar is Lecturer, Interdisciplinary School of Health Sciences, University of Pune, Pune, Maharashtra, India.

INTRODUCTION

Of the various transitions that have occurred during the past few decades, the best-known transition and the one of most interest to demographers is demographic transition. Briefly defined, demographic transition is a process in which countries or societies move from the phase of high fertility and high mortality (with low rate of natural increase of the population) to low fertility and low mortality (another phase of low rate of natural increase of the population). In this process, along with the decline in birth rates, decline in death rates —
more specifically in infants and in children — and increase in the expectation of life is expected. Thus, transition is equally beneficial to both men and women of all ages in the population. However, it is noticed that women, in general, and girl children, in particular, have not benefited like males from the decline in death rates as observed in the Sample Registration System (SRS) data (Agnihotri, 2001).

Declining fertility is beneficial to national governments at the macro level and to families at the micro level. As the family size norm goes down, replacement level of fertility can be reached faster. However, if adherence to the two-child norm is leading to female foeticide, as is happening in countries like China, Taiwan and South Korea, it is a grave matter. Achievement of replacement level fertility, which is desirable, cannot be a matter of pride if girls and women are treated as 'social inferiors' and are deprived of the fundamental rights and economic opportunities accorded to men.

In the history of demographic transition of various developing countries, it is seen over time that persistence of gender inequality did not come in way of achieving this transition. It has been experienced that at times, in some countries, women's reproductive health has been compromised in the pursuit of controlling population growth rates. For example, it was observed in the erstwhile Soviet Union and Eastern European countries that laws regarding induced abortion were made liberal when the state wanted to curb the rate of population growth and abortion laws were made stringent when the state wanted to encourage fertility. Ideally, demographic transition should be as is stated by the Population Council (1996):

in our view, the desired transition (demographic) is one in which slowed population growth brings with it equitably distributed social and economic gains that are accompanied by gender equality both within the family and throughout the wider community.

The present article tries to examine gender inequalities in Maharashtra in the wake of demographic transition. It is argued that despite the demographic transition occurring in Maharashtra, the status of women has not improved as it happened in the more developed countries. On the contrary, some crucial indicators such as the sex ration or the numerical balance of men and women reveal a rise in gender inequality. The article is structured around the following points:

• The course of fertility and mortality decline in Maharashtra and demographic transition since 1971.
• Gender inequalities in terms of sex ratio, son preference, age at marriage of girls, practice of contraception, and other aspects of family support.

DEMOGRAPHIC TRANSITION IN MAHARASHTRA

Demographic transition was experienced by the developed Western world first. It was a slow process when high fertility and high mortality gradually declined to reach low fertility and low mortality levels. The process took a considerable amount of time and simultaneously social development also took place. Educational levels of women increased, they started working and slowly improved their status in the family and in the society. It is argued by some scholars that fertility transition in the Western world from high to low levels has been associated mainly with improving gender equity within the family (McDonald, 2000). Unfortunately, this did not happen in the developing world. Though the death rates of developing countries declined very rapidly (due to the benefits of public health in the developed world being available to them directly), birth rates started declining slowly and that too only because of vigorous family planning programmes. Since the transition did not happen as in the developed world, the process of social development is still incomplete.

The crude birth rate (CBR) in Maharashtra declined to 20.9 in 2000 (India, 2001b) from 32.2 in 1971, showing about 35 per cent decline. For the same period, the decline in total fertility rate (TFR) was from 4.6 children in 1971 to 2.5 children during 1996-1998, as observed in the National Family Health Survey (NFHS)-2 (Indian Institute for Population Sciences [UPS] and ORG Macro, 2001) — a drop of 46 per cent. Decline in the crude death rate (CDR) during this period was from 12.3 to 7.5 — a decline of 39 per cent. The natural growth rate for the same period declined from 19.9 to 13.2 per 1000 population. According to the NFHS-2, 61 per cent of the couples in the reproductive age group were practising some kind of contraception in 1998-1999. With a TFR of 2.5 children, Maharashtra is close to achieving replacement level fertility. In its population policy, the Government of Maharashtra has declared its aim to bring down the TFR to 2.1, which is the replacement level fertility, and that of the infant mortality rate (IMR) to 25 and neo-natal mortality rate to 20, by 2004. The State desires to vigorously promote the 'two-child family norm' and has introduced schemes for providing incentives and disincentives towards achieving the goal (Kanitkar, 2001).
According to the National Fertility and Mortality Survey (NFMS) of Maharashtra, conducted in 1980, the number of children considered ideal by married women was 3.2 (Srikantan and Bhide, 1989). The average ideal family size according to ever-married women as observed in the NFHS-1, conducted in 1992-1993, was 2.5 children (with 1.3 sons, 0.9 daughters and 0.3 of either sex). During the six-year period from NFHS-1 to NFHS-2, a slight change was observed in the average ideal family size as reported by ever-married women with the ideal family size of 2.3 children (1.3 sons, 0.9 daughters and 0.1 of either sex). However, there is a decline of 0.9 children in the ideal family size during the course of 18-19 years and is approaching replacement level fertility. During the period between two NFHSs, the ideal number of sons has not gone down.

A large amount of fertility decline in Maharashtra during 1980 to 1992-1993, from NFMS to NFHS-1, has been due to the decline in marital fertility (Mulay, 1998), which was effected mainly due to state intervention — the family planning programme (now Family Welfare Programme). The factor marital status composition has contributed little for the decline. The main emphasis of the family planning programme in Maharashtra has been on sterilisation — earlier on vasectomies and later on and till now on female sterilisation. In this state-run family welfare programme, there was little informed choice, less screening, less attention to the quality of care, haphazard follow-up services, no provision for the management of unwanted pregnancies, and very little emphasis on the spacing methods (Kanitkar, Dayalchand, Kapadia-Kundu and Khale, 1997). The family planning programme neglected adolescents and the prevention and management of reproductive services were sidetracked. Achievement of demographic transition (replacement level fertility) became a goal in itself and important issues such as improved reproductive health and gender equity were neglected (Kanitkar and others, 1997; Maharashtra, 2000).

Status of Women: Numerical Paucity of Women

Sex ratio here is expressed as the number of women per 1000 men and a figure less than 1000 indicates numerical deficiency of women. During the period of demographic transition, sex ratio in Maharashtra, as in India, has gone down indicating the declining status of women. The most disquieting result of 2001 Census in Maharashtra, apart from the population size and more than average growth rate (which was expected) in the decade, was a sharp decline
in the sex ratio of the population of 0-6 years as well as in the population of persons in the age group of 7 years and above. In 1981, the sex ratio of the total population was 937; it declined to 934 in 1991 and further to 922 in 2001 — a decrease of 15 women per 1000 males in the period of 20 years. This is definitely a worrying feature and reiterates the lowering status of women. Of more particular concern is the decline in the sex ratio of child population, that is the sex ratio of population below 6 years of age. It was 956 in 1981, 946 in 1991 and dropped sharply to 917 in 2001 (See Table 1). This decrease of 39 baby girls in 20 years deserves more concern.


<table>
<thead>
<tr>
<th>Census Year</th>
<th>Sex Ratio 0-6 years</th>
<th>Sex Ratio 7 years and above</th>
<th>Total population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1981</td>
<td>956</td>
<td>933</td>
<td>937</td>
</tr>
<tr>
<td>1991</td>
<td>946</td>
<td>931</td>
<td>934</td>
</tr>
<tr>
<td>2001</td>
<td>917</td>
<td>923</td>
<td>922</td>
</tr>
</tbody>
</table>

*Source: India (2001a: 92, 94).*

Pre-natal sex determination became available in the late 1970s and spread like wildfire during the eighties and the nineties. Its wide use in the pre-determination of the sex of the foetus and subsequent abortion of the female foetus is very clearly visible in the values of the sex ratios — more specifically of the children aged 0-6 years of last two censuses. At the end of eighties, pre-natal sex determination tests were banned. Maharashtra was the first state in India to pass the Maharashtra Regulation of Pre-natal and Diagnostic Techniques Act in 1988. This law was totally ineffective, which is reflected in the drastic decline in child sex ratio here.

As the sex ratio of Maharashtra is also greatly affected by the volume and pattern of migration, it is difficult to venture any analysis about the decline in the sex ratios of the general population. Hence, in the following section, the focus will be on the decline of the child sex ratio in Maharashtra. Discussion on trends in the child sex ratio from 1981 to 2001 in the districts of Maharashtra is also presented.

**Trends in the Sex Ratio of Child Population Aged 0-6 years**

Table 2 presents the sex ratio of population aged 0-6 years as per three consecutive censuses — 1981, 1991 and 2001 — in the districts
of Maharashtra. It is to be noted that information presented is for 26 districts for 1981 and 1991 and for 35 districts for 2001. Decline in child sex ratios appears to be a universal feature for all the districts of Maharashtra.

TABLE 2: District-Wise Trends in Sex Ratio of Children Aged 0-6 Years for Maharashtra, 1981-2001

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Nandurbar</td>
<td>-</td>
<td>-</td>
<td>966</td>
</tr>
<tr>
<td>Dhule</td>
<td>984</td>
<td>960</td>
<td>907</td>
</tr>
<tr>
<td>Jalgaon</td>
<td>958</td>
<td>925</td>
<td>867</td>
</tr>
<tr>
<td>Buldhana</td>
<td>962</td>
<td>945</td>
<td>915</td>
</tr>
<tr>
<td>Akola</td>
<td>980</td>
<td>934</td>
<td>936</td>
</tr>
<tr>
<td>Washim</td>
<td>-</td>
<td>-</td>
<td>921</td>
</tr>
<tr>
<td>Amravati</td>
<td>955</td>
<td>934</td>
<td>947</td>
</tr>
<tr>
<td>Wardha</td>
<td>929</td>
<td>952</td>
<td>934</td>
</tr>
<tr>
<td>Nagpur</td>
<td>946</td>
<td>951</td>
<td>949</td>
</tr>
<tr>
<td>Bhandara</td>
<td>996</td>
<td>971</td>
<td>958</td>
</tr>
<tr>
<td>Gondiya</td>
<td>-</td>
<td>-</td>
<td>964</td>
</tr>
<tr>
<td>Gadchiroli</td>
<td>-</td>
<td>-</td>
<td>973</td>
</tr>
<tr>
<td>Chandrapur</td>
<td>994</td>
<td>970</td>
<td>944</td>
</tr>
<tr>
<td>Yavatmal</td>
<td>978</td>
<td>960</td>
<td>942</td>
</tr>
<tr>
<td>Nanded</td>
<td>961</td>
<td>960</td>
<td>944</td>
</tr>
<tr>
<td>Hingoli</td>
<td>-</td>
<td>-</td>
<td>935</td>
</tr>
<tr>
<td>Parbhani</td>
<td>993</td>
<td>955</td>
<td>926</td>
</tr>
<tr>
<td>Jalna</td>
<td>-</td>
<td>-</td>
<td>914</td>
</tr>
<tr>
<td>Aurangabad</td>
<td>944</td>
<td>940</td>
<td>884</td>
</tr>
<tr>
<td>Nashik</td>
<td>956</td>
<td>954</td>
<td>936</td>
</tr>
<tr>
<td>Thane</td>
<td>966</td>
<td>952</td>
<td>933</td>
</tr>
<tr>
<td>Mumbai (suburb)</td>
<td>-</td>
<td>-</td>
<td>919</td>
</tr>
<tr>
<td>Mumbai</td>
<td>-</td>
<td>-</td>
<td>898</td>
</tr>
<tr>
<td>Raigad</td>
<td>984</td>
<td>961</td>
<td>943</td>
</tr>
<tr>
<td>Pune</td>
<td>949</td>
<td>942</td>
<td>906</td>
</tr>
<tr>
<td>Ahmadnagar</td>
<td>970</td>
<td>949</td>
<td>893</td>
</tr>
<tr>
<td>Beed</td>
<td>967</td>
<td>940</td>
<td>898</td>
</tr>
<tr>
<td>Latur</td>
<td>-</td>
<td>-</td>
<td>923</td>
</tr>
<tr>
<td>Osmanabad</td>
<td>997</td>
<td>947</td>
<td>925</td>
</tr>
<tr>
<td>Solapur</td>
<td>984</td>
<td>935</td>
<td>897</td>
</tr>
<tr>
<td>Satara</td>
<td>953</td>
<td>941</td>
<td>884</td>
</tr>
<tr>
<td>Ratnagiri</td>
<td>1031</td>
<td>962</td>
<td>954</td>
</tr>
<tr>
<td>Sindhudurg</td>
<td>-</td>
<td>-</td>
<td>946</td>
</tr>
<tr>
<td>Kolhapur</td>
<td>955</td>
<td>931</td>
<td>859</td>
</tr>
<tr>
<td>Sangli</td>
<td>945</td>
<td>924</td>
<td>850</td>
</tr>
<tr>
<td>Maharashtra</td>
<td>951</td>
<td>945</td>
<td>917</td>
</tr>
</tbody>
</table>

Source: India(2001a).
It is obvious that the child sex ratio declined considerably in all the districts of Maharashtra. In 1981 and 1991 there was not a single district with child sex ratio less than 900. Suddenly in 2001 there are nine districts in this category. Similarly, in 1981 there was not a single district, which recorded child sex ratio between 900 and 925 and in 1991 there were 11 districts in this category.

Current Situation Regarding Child Sex Ratio

There is a wide variation in the sex ratios of the child population of Maharashtra with 973 girls per 1000 boys in Gadchiroli district and 850 in Sangh. Districts with the sex ratio below 900 are Jalgaon, Aurangabad, Ahmadnagar, Beed, Satara, Sangh, Kolhapur, Solapur and Mumbai. All these districts (except Mumbai) form one broad vertical belt. These districts, excluding Beed, have become richer because of sugar producing industries. This vertical band of districts known as the 'sugar belt' of Maharashtra has the least child sex ratio. Politically, this belt wields good amount of power in the state. The rural areas in this inland Western region are comparatively richer as only eight per cent of its rural population falls under the category of the 'very poor' (Srinivasan, Thiagarajan and Shastri, 2001). Broadly, sex ratios are inversely associated with income.

Analysis of the sex ratio for various communities for 1931 census threw a surprising finding. It was observed that among Hindus the ratio of females to males increased inversely with the socioeconomic standing of the community. In Bombay Presidency, the sex ratios for the advanced, intermediate and backward classes were 878, 935 and 956 respectively and for the depressed classes it was 982 females per 1000 males (Kanitkar, 1992). The same is reflected from 2001 Census data — the highest sex ratio (973) is in a backward district like Gadchiroli and the lowest sex ratio (850) is in rich Sangh.

In the 'sugar belt' region of Maharashtra, the patriarchal system wherein the men dominate over women, in economic, cultural and familial matters is very much in evidence. In such patriarchal societies, sons are preferred over daughters for various reasons. Thus, along with son preference here, additionally, tests for pre-determination of sex of the foetus are easily available. People have the means to avail these of the tests and abortion is legal, though not for this cause. As such there could be a strong possibility that female foeticide, following pre-natal determination of sex, is a major factor in the declining sex ratio in this region.
Sex Ratio at Birth: Unborn Girls

The 1991 census results sent shockwaves as they showed an unexpected decline in the sex ratio for India and several states, including Maharashtra. Fortunately, the figures for child population (age 0-6 years) were available this time to obtain a denominator to calculate literacy rates. This provided an opportunity for the researchers to study the sex ratio of the child population. It was observed that the sex ratio of children was also declining. This prompted census authorities to look into the phenomenon of sex ratio at birth. For the first time in India, a supplement taken out for the analysis of sex ratio already done in Paper 1 of the Provisional Population Totals of the Census Report of 1991 drew the attention of researchers to the phenomenon of sex ratios at birth. It was seen that sex ratio at birth was becoming more masculine. Based on 6 million live births that occurred in the country during 1981-1991, the sex ratio at birth was 891 (112 boys per 100 girls). This was much higher than what was observed (105-106 boys per 100 girls) in a study during 1949-1958 (Ramachandran and Deshpande, 1964). The SRS data on live births also showed a rise in the sex ratio at birth 1984-1988 where the sex ratio at birth was 110 boys per 100 girls (India, 1992). The SRS also indicated that the male-female mortality in age group 0-4 years had declined. Therefore, at the end of analysis of the sex ratios, the Office of the Registrar General hypothesised that the declining sex ratio at birth seemed to be one of the probable reasons for the decline in the sex ratio (India, 1992).

Paper 1 of 2001 census, based on SRS data, drew attention to the declining sex ratio at birth at various points of time during 1982-1984 to 1996-1998. It seems that during 1994 to 1996, the sex ratio was the lowest at 875 or 114 boys per 100 girls (India, 2001a). Thus, it is indicated that the sex ratio at birth in the country is lower than the generally accepted range of 943-952. The sex ratio at birth in Maharashtra was 109 boys per 100 girls in 1996-98 — sizably higher than expected.

Census findings of the abnormally high sex ratios of young children are confirmed by the results of two NFHSs taken at an interval of six years (1992-1993 and 1998-1999) to provide a clear evidence of increase in the pre-natal sex determination and subsequent abortion of female foetus. In 1992-1993, as per NFHS-1, the sex ratio at birth was 106.1 boys per 100 girls and in 1998-1999, it had increased to
110.6 (Arnold, Kishor and Roy, 2002). A little less than one-third (31 per cent) of pregnant women (among women who had had a live birth in the past three years period) had gone for ultrasound or amniocentesis. Thus, the NFHS-2 confirmed that the sex ratio of recent births in Maharashtra had been abnormally high, exceeding 110 boys per 100 girls. The NFHS-2 also provided convincing evidence that sex selective abortions were a common practice in many parts of India (Arnold and others, 2002).

**Missing Women**

Concern regarding the numerical paucity of women in India is as old as the census taking itself. All census commissioners have shown a keen interest in the sex ratio in India and its provinces (before Independence). The finding that there was a paucity of women in India shocked the British census-takers, as the situation regarding sex balance was just the opposite in England and Wales. In each census report, from 1871 to 1981, there is a separate chapter on 'sex proportion' in which interpretations of the relative number of males and females are provided. This chapter in the 1891 Census report opens with the statement,

> Of the many problems that come to light in the course of reviewing the results of the Census of Indian provinces, none is more perplexing that of having to account for the varying proportion of the two sexes in different parts of the country (Census of India, 1891, General Report).

After more than a 100 years, the most 'perplexing' aspect of the Census of India is to explain the numerical deficit of women. Pandita Ramabai Saraswati also observed this deficit in the number of women after the 1881 Census. She realised that a deficit of over five million women this was an unnatural phenomenon and tried to look into its causes. Ramabai (1988) stated

> ... Chief among the causes which have brought about this surprising numerical differences between the sexes may be named, after female infanticide in certain parts of the country, the imperfect treatment of the diseases of women in all parts of Hindustan, together with a lack of proper hygienic care and medical attendance.

After more than 100 years, the situation has still not improved much. Additionally, modern techniques have been resorted to perpetuate the age-old idea of son preference. Throughout the history of the
Census of India, till the 1991 census, the main factor responsible for the numerical deficit of females was excess female mortality (Kanitkar, 1991). Authoritative studies on the masculinility of the Indian population showed that the persistence of a sex ratio, which was unfavourable to women, was not due to greater omissions of females in the censuses, or from the unusually high sex ratio (favourable to males) at birth, but because of unusually high mortality rates for females as compared to males (Coale, 1991; Visaria, 1968). The numerical impact of higher female mortality was expressed in terms of 'missing women'. The concept of 'missing women' was devised by Amartya Sen to give a rough idea of the enormity of the problem. Sen's first estimate of missing women in India was 37 million (Sen, 2001). Similarly, though on a lower level, assuming that the 1991 sex ratio for Maharashtra (934) would not have declined in 2001 (922), a simple calculation gives an estimate of the missing women in Maharashtra as 3,07,255 during a 10-year period.

Sen (2001) also refers to the abortions of the female foetuses after determination of the sex of the foetus as 'natality inequality'. According to him, this high-tech sexism was responsible for the fall in female births vis-a-vis male births. This is reflected in the fall in the child sex ratio in Maharashtra and some other richer states such as Punjab and Haryana. Premi (2001) has also supported this point. Recently, the female disadvantage in mortality has narrowed in Maharashtra, as in other states. According to SRS, the expectation of life at birth in Maharashtra was 62.0 years for males and 64.7 for females in 1988-1992 and the per annum increase in the expectation of life was 0.60 years (India, 1995). The situation must have improved after 1988-1992.

Son Preference
It has been observed in East Asian countries — China, South Korea, Taiwan and Singapore — that fertility decline resulted in the sex ratio becoming unusually masculine, because these societies suffered from the syndrome of 'son preference' (Sen, 2001). When fertility declines, the total number children desired falls more rapidly than the total number of sons desired (Dasgupta and Bhat, 1996). The same has happened in Maharashtra. Based on the reported ideal family size and ideal number of sons and daughters, an index of intensity of son preference can be computed. The range of this index is -100 to +100, indicating preference for daughters only (-100) and sons only (+100).
This index is calculated using data from three large surveys conducted in Maharashtra. According to the Srikantan and Bha te (1989), in the NFMS the index turned out to be 18.8, which was reduced to 16.0 and 12.5 for the NFHS-1, and the NFHS-2 respectively. Considering the decline in fertility during 1980 to 1998-99, decline in the intensity of son preference is proportionally less.

Muthurayappa, Choe, Arnold and Roy (1997) have also reported strong son preference in Maharashtra during the NFHS-1. In both NFHS-1 and NFHS-2, it was revealed that between the two child couples, the proportion of couples accepting terminal methods after two living sons was much more than couples accepting terminal methods after two living daughters. The same pattern was observed for couples with three or four children or more. Son preference in Maharashtra has also contributed to an increase in fertility to the extent of 15 per cent (Muthurayappa and others, 1997).

The main reasons for son preference in Maharashtra, as cited by both men and women, are continuation of family line and old age support (Radkar, 1999). Both these reasons are consistent with the deep-rooted patriarchal system and lower status of women. Son preference in Maharashtra is persistent, irrespective of the social and economic development of the state. We would like to mention here that, during 1991-2001, the literacy rates for females increased and the difference between the male and female literacy rate has narrowed: female literacy rate was lower than male literacy rate by 47 per cent in 1991 and by 28 per cent in 2001. There has been an increase in the labour force participation rate of women in Maharashtra from 1992-93 to 1998-99 from 49 to 54 per cent (UPS, 1994; UPS and ORG Macro, 2000). Women's exposure to mass media has also increased (UPS, 1994; UPS and ORG Macro, 2000). It is a matter of concern that despite increase in these important developmental aspects, gender inequality persists. Indeed, Sen (2001) is of the opinion that the traditional routes of changing gender inequality through increase in female education and economic participation may not serve as a path to remove 'natality inequality'. The best evidence is provided by countries such as China, South Korea, Singapore and Taiwan that have higher level of female education and female labour force participation and have lower than biologically observed sex ratio at birth.

Both the NFHSs have revealed that in Maharashtra boys are more likely to be fully vaccinated than girls. There is a substantial evidence of malnutrition among girls in tribal areas and urban slums of
Tara Kanitkar and Anjali Radkar

Maharashtra (Khale, Kanitkar, Dayalchand and Koshi, 1997; Institute of Health Management Pachod, 1996). A longitudinal study over a 15-year period in rural areas of Paithan Taluka of Maharashtra, indicates that prevalence of severe malnutrition had reduced from 14 per cent in 1977 to 3 per cent in 1992 and the proportion of severely malnourished girls is two to three times that of boys (Khale, and others, 1997). In rural Maharashtra, it was observed that the average cost of treatment for illnesses (acute respiratory infection, diarrhoea, fevers, measles and others) was Rupees 240 for the boys and Rupees 120 for girls (Institute of Health Management, 1996) clearly indicating discrimination against the girl child.

Age at Marriage

Age at marriage of girls is another indicator of social development. In Maharashtra it was recorded as 16.4 and 17.0 years respectively for NFHS-1 and NFHS-2 for ever-married women, in the ages 20-49 years. Age at marriage has, thus, recorded only a slight increase during this period (UPS, 1994; UPS and ORG Macro, 2000). It was further observed in NFHS-2, that the median age at marriage in rural Maharashtra for the youngest cohort of girls aged 20-24, was 17 years indicating not much change in the nuptiality pattern. In rural Maharashtra, during NFHS-2, 62 per cent of the girls were married before 18 years. Lower age at marriage associates with the lower status of the girls here.

Gender Inequality in the Practice of Family Planning Methods

One important dimension of the reproductive and child health focus is to enhance male participation by ensuring that men take the responsibility for family planning, family support and child rearing. Men's participation, it is thought, can help in slowing the spread of HIV/AIDS and other sexually transmitted diseases. By assuming the responsibility for the consequences of their sexual behaviour, men can protect themselves, their partners and their families. Men can help in avoiding unintended pregnancies either by using contraceptive methods or by supporting their partners in the use of family planning methods. They can also promote safe motherhood by supporting their partners during pregnancy, childbirth and childcare. The International Conference on Population and Development has specified the need to increase the participation of men in the actual practice of family
planning (UNFPA, 1995). The interest in increasing the active male participation in family planning is mainly because of two aspects:

1. It balances the contraceptive use more evenly between men and women, and thus, increases gender equity; and


It becomes necessary to find out the extent men in Maharashtra are supportive to women in practising family planning and other matters and, thus, help in achieving gender equity.

In order to investigate into the involvement of men in family planning methods, information obtained from NFHS-1 and NFHS-2 were used. Data from two studies, one carried out in Pune slums and one in Marathwada villages in 1998 by the Institute of Health Management, Pachod, and its Pune Centre were also used. From Table 3, which presents the distribution of current users of contraceptive methods by methods used by place of residence, it is clear that the use of family planning methods in Maharashtra was 61 per cent in 1999 with 59 per cent in urban and 63 per cent in rural areas. It is also evident that male involvement in family planning is very small — only 14 per cent of all the men (15 per cent in urban and 14 per cent in rural areas) were using male dependent methods. In Pune slums and in Marathwada villages, the male involvement was even smaller. Compared to the NFHS-1, the proportion of the use of male dominated methods has gone down from 18 per cent to 14 per cent in the NFHS-2. Of all couples using contraception, 7 per cent were using condoms and 6 per cent of the husbands were sterilised. It is surprising that despite the enormous threat of HIV/AIDS in Maharashtra, more specifically in urban slums, only less than 3 per cent were using condoms. Female sterilisation was by far the mainstay of contraceptive use.

The NFHS-2 has shown a downward trend in male sterilisation with only 4 per cent of the couples accepting it: 1.5 per cent in urban and 5.3 per cent in rural areas of the state. According to service statistics here, the proportional share of male sterilisation in total sterilisation was only 3 per cent in 1992-93, which reached 1.6 per cent in 1995-96 and 1.4 per cent in 1996-97 (Talwalkar, 1997).

Thus, it is clear that the men in Maharashtra do not equally share the responsibility of fertility regulation. The preponderance of female sterilisation in Maharashtra could be due to the promotion of female sterilisation by the health providers. The fact, however, that women ask for sterilisation should not be lost sight of. In fact, this is the only
TABLE 3: Percent Distribution of Contraceptors by Method Currently Used (by Place of Residence), Maharashtra, 1998-1999

<table>
<thead>
<tr>
<th>Study</th>
<th>Female Methods</th>
<th>All Female Methods</th>
<th>Male Dependent Methods</th>
<th>All Male Dependent Methods</th>
<th>Current Use of any Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pill</td>
<td>IUD</td>
<td>Female Sterilisation</td>
<td></td>
<td>Male Sterilisation</td>
</tr>
<tr>
<td>NFHS-2 1998-99</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>4.3</td>
<td>6.0</td>
<td>74.5</td>
<td>84.8</td>
<td>2.6</td>
</tr>
<tr>
<td>Rural</td>
<td>1.9</td>
<td>1.3</td>
<td>82.8</td>
<td>86.0</td>
<td>8.5</td>
</tr>
<tr>
<td>Total</td>
<td>2.8</td>
<td>3.1</td>
<td>79.6</td>
<td>85.6</td>
<td>6.1</td>
</tr>
<tr>
<td>Pune Slums 1998</td>
<td>2.8</td>
<td>1.6</td>
<td>90.2</td>
<td>94.6</td>
<td>1.6</td>
</tr>
<tr>
<td>Marathwada</td>
<td>1.5</td>
<td>1.2</td>
<td>87.0</td>
<td>89.7</td>
<td>5.5</td>
</tr>
</tbody>
</table>

method (referred to as ‘operation’) universally known (Kanitkar and Kulkarni, 2001). Men find this convenient and, thus, stay aloof.

**Gender Inequality in Family Support**

In other matters of reproductive health such as support to wives during pregnancy, maternity and childcare, participation of men is almost absent. It is considered as an area for the elderly in the family (Rajaram, Ramesh and Inge, 2001). A study in the rural areas of Marathwada revealed that according to women respondents, only 27 per cent of husbands helped in bringing water, 18 per cent helped fetching firewood and 6 and 5 per cent helped in sweeping and cooking (respectively) when they were pregnant (Dayalchand, 2001). This very clearly indicates that husbands do not support their pregnant wives.

**SUMMARY AND CONCLUSIONS**

An attempt has been made to study the status of women measured in terms of various forms of gender inequalities in Maharashtra at a stage, when the state is close to approaching replacement level fertility and, thus, demographic transition. Initially, the course of demographic transition in Maharashtra is traced. The state-run family planning programme plays a major role in fertility decline through sterilisations. The gender inequalities have persisted despite the state nearing the replacement level fertility (TFR = 2.1). It is argued — based on the varied evidences from different sources — that although the state has reached replacement level fertility the status of women has gone down. It is observed that the ratio of females to males among children in age group 0-6 years has lowered during the period of demographic transition. This has been mainly due to abortion of female foetuses following the determination of sex of the foetus. It was noticed that the child sex ratio had declined in all the districts of Maharashtra during 1981-2001. A sex ratio of below 900 is observed in nine districts that formed a wide vertical belt wherein sugar industries are located. This area is comparatively richer with smaller proportion of poor people. As in most other parts of India, preference for son also exists in this part of Maharashtra. The facility of pre-natal determination of sex is available, even though it is illegal, as people have the money and the abortions are legal. A study on induced abortions done in the rural areas of this part of Maharashtra revealed that 17 per cent of abortions were preceded by pre-natal sex
determination tests confirming female foetuses (Ganatra, Hirve, Walwalkar, Garda and Rao, 1995). Another study on abortions among married women in the villages situated in urban fringes revealed the extent of sex selective abortions to be 11 per cent (Radkar, 2004).

The study comes to the conclusion that demographic transition in Maharashtra has not helped to reduce inequality between males and females; on the contrary the numerical imbalance has increased. The 'unholy alliance' between technology and tradition has proved dangerous to the existence of women and may be eventually to the nation. The study also points out the fact that girls in Maharashtra are still married at younger ages. A substantial proportion of girls, more specifically in rural Maharashtra, are married before they attain 18 years — the minimum legal age for marriage. It is also evident that male participation in the current practice of family planning methods is declining.

The study emphatically points out that despite the increase in the literacy rate of women in Maharashtra, an upward trend in their participation in economic activities, and exposure to mass media during the course of demographic transition, gender inequalities have not decreased. On the contrary there is a rising trend and modern technology has been used to perpetuate traditional values.

REFERENCES

Agnihotri, S. 2001


Census of India 1891

Coale, A.J. 1991

Dasgupta, M. and Bhat, M. 1996
*Intensified Gender Bias in India*. Paper presented at the Annual Meeting of the Population Association of Amer-
Dayalchand, A. 2001


Ganatra, B.R., 2001


Ganatra, B.R., 1996

Institute of Health Management 1996

Garda, L., and Rao, V.N. 1996

: Social Assessment of ICDS III, Pachod.


International Institute for Population Sciences

Social Assessment of ICDS III, Pachod.

International Institute for Population Sciences

National Family Health Survey, Mumbai.

International Institute for Population Sciences and ORG Macro 2001

National Family Health Survey-2, Mumbai.

Kanitkar, K. 1991


Kanitkar, T. 2001


Kanitkar, T. and Kulkarni, S. 2001

Reproductive and Child Health in Target Free Setting in Maharashtra: Policy Implications, Pachod: Institute of Health Management.


Kanitkar, T. and Kulkarni, S. 2001

Involvement of Males in Practice of Contraception in Maharashtra, Demography India, 31(1), 1-15.

Kanitkar, T. and Kulkarni, S. 2001

Khale, M., Kanitkar, T., 1997


Dayalchand, A. and Koshi 1997

McDonald, P. 2000


Mulay, S. 1998


*The High Cast Hindu Woman* (First published in 1888 by George Bell and Sons, London), Reprinted by Hypiian Press Inc, West Port.


*Abortions in Rural Communities Near Urban Areas: The Experience of Married Women*, Mumbai: Health Watch Trust, and CEHAT.


Sex Ratio at Birth in India by Regions, *The Milbank Memorial Fund Quarterly*, 42(2), 82-85.


*National Fertility and Mortality Survey in Maharashtra 1980*, Study, Number 70, Pune: Gokhale Institute of Politics and Economics.


State Population Policy, Mumbai: Public Health Department.

United Nations 1991
UNFPA 1995
Visaria, P. 1968

The Sex Ratio of the Population of India.